

SECTION 1 MATERNAL AND CHILD HEALTH (MCH) BRANCH MCH PROGRAM

Background

The federal MCH Block Grant to states is authorized under Title V of the Social Security Act of 1935. The MCH Branch makes application to the federal government annually to maintain the Title V programs in the MCH Branch and in the Children's Medical Services Branch consistent with federal and state performance and outcome measures.

The Title V MCH program has the following focus:

- To provide and assure mothers and children (especially those with low income or limited availability to services) access to quality MCH services.
- To reduce infant mortality; to reduce the incidence of preventable diseases and handicapping conditions among children; to reduce the need for inpatient and long-term care services; to increase the number of children (especially preschool children) appropriately immunized against disease; to increase the number of low income children receiving health assessments and follow-up diagnostic and treatment services; to promote the health of mothers and infants by providing prenatal, delivery, and postpartum care for low income, at-risk pregnant women; and to promote the health of children by providing preventive and primary care services for low-income children.
- To provide rehabilitation services for blind and disabled individuals under the age of 16 years receiving benefits under Title XVI, to the extent medical assistance for such services is not provided under Title XIX.
- To provide and promote family-centered, community-based, coordinated care (including care coordination services as defined in the legislation) for Children with Special Health Care Needs (CSHCN) and to facilitate the development of community-based systems of service for such children and their families.

In 1997, Section 123255 was added to the California Health and Safety Code. The statute specifies the structure and requirements for state-funded local programs of MCH. (Please refer to Appendix for the full text of this section of the statutes.) Other statutes and regulations include:

- U.S. Code of Regulations Title 42, The Public Health and Welfare, Chapter 7, Social Security, Subchapter V—Maternal and Child Health Services Block Grant.
- California Health and Safety Code Section 123225-123255, Maternal and Child Health Program.
- California Health and Safety Code Section 123475-123525, Comprehensive Perinatal Services Program.
- California Welfare and Institutions Code Section 14132-14134.5, Medi-Cal Coverage of Comprehensive Perinatal Services.
- California Code of Regulations, Title 22. Social Security, Division 3. Health Care Services, Subdivision 1. California Medical Assistance Program, Chapter 3. Health Care Services, Article 3. Standards for Participation, Section 51249. Application Process for Comprehensive Perinatal Providers.
- California Health and Safety Code Section 104560-104569, Comprehensive Perinatal Patient/Client Education and Community Awareness Program.
- California Health and Safety Code Section 123550-123610, Regional Perinatal Program Coordinators.
- California Health and Safety Code Section 123725-123745, Sudden Infant Death Syndrome.
- California Health and Safety Code Section 12450-12451, Domestic Violence.
- California Code of Regulations, Title 17, Public Health, Division 1. State Department of Health Services, Chapter 3. Local Health Service, Subchapter 1. Standards for State Aid for Local Health Administration, Article 1. Organization, Section 1253. Public Health Nursing Staff.
- Senate Bill (SB 165), Budget Act of 1989 (Alquist, Chapter 93, Statutes of 1988), Black Infant Health Program.
- California Welfare and Institutions Code Section 14134.5.

Under the MCH umbrella, there are four specialized programs, Adolescent Family Life Program (AFLP), Adolescent Sibling Pregnancy Prevention Program (ASPPP), Black Infant Health (BIH) Program, and Fetal Infant Mortality Review (FIMR). These programs are not required and a health jurisdiction may have one

or more of these programs. Each specialized program has an assigned consultant and a separate scope of work (SOW). AFLP and BIH require a separate budget; however, FIMR costs are included in the local MCH budget. These are necessary to maintain specific program and budgetary mandates, which are covered in separate sections of this manual.

The MCH Branch allocates funding annually to support MCH programs developed, operated, and managed by local health jurisdictions and community-based organizations (CBOs) throughout California. Through the Allocation Funding Application (AFA), the Branch assures that each local health jurisdiction has the leadership and resources to carry out the core public health functions of assessment, policy development, assurance, and evaluation to improve the health of their MCH population. To forecast an annual budget, each health jurisdiction must establish a scope of work for the following year based on the identified needs of the jurisdiction and the state and federal MCH objectives. Federal Title V MCH Block Grant Funds, State General Funds, Federal Title XIX Medicaid (Medi-Cal) Funds, and local government (county/city) funds are combined to support the program activities as defined in the scope of work. The SOW is developed based on performing specified activities and evaluating the results aimed at achieving the following Title V goals, objectives, and priorities:

Goals:

- **Goal 1:** All children are born healthy to healthy mothers.
- **Goal 2:** No health status disparities among racial/ethnic, gender, economic, and regional groups.
- **Goal 3:** A safe and healthy environment for women, children, and their families.
- **Goal 4:** Equal access for all women, children, and their families to appropriate and needed care within an integrated and seamless system.

Objectives:

- Reduce pregnancies among females aged 15-17 to no more than 50 per 1,000 females aged 15-17.
- Reduce the percent of women 18 years and older that report experiencing some form of intimate partner physical violence in the past 12 months.
- Increase to at least 90 percent the proportion of all pregnant women who receive prenatal care in the first trimester of pregnancy.
- Increase to at least 90 percent the proportion of pregnant women and infants who receive risk-appropriate care.
- Reduce very low birth weight to no more than one percent of all live births.
- Increase to at least 75 percent the proportion of mothers who breastfeed their babies in the early postpartum period and to at least 50 percent the proportion who continue breastfeeding until 5 to 6 months old.
- Ninety percent of children will have completed the full immunization schedule through age 2 (19-36 months).

- Increase to at least 50 percent the proportion of children who have received protective sealants on the occlusal (chewing) surfaces of permanent molar teeth.
- Reduce the rate of deaths to children aged 0 through 4 years caused by drowning to no more than 2.3 per 100,000 children aged 0-4 years.
- Reduce the rate of deaths to children aged 14 and younger caused by motor vehicle crashes to no more than 3.5 per 100,000 children aged 1-14.
- Reduce the percent of youth 12-17 years of age in California who report having smoked cigarettes in the past 30 days.
- Reduce the rate of deaths to adolescents aged 15-19 years caused by homicide.
- Reduce the rate of deaths to adolescents aged 15-19 years caused by motor vehicle injuries.
- Reduce the rate of suicides to no more than 8.2 per 100,000 youths aged 15-19.

The state MCH Branch has developed the following California priorities that will determine the Title V activities over the next 5 years based on the priority needs of the State:

- Eliminate racial and ethnic disparities in infant health, including gaps in the infant mortality rate and the proportion of low and very low birth weight live-born infants.
- Promote safe motherhood by improving early access to and the quality of maternal health care for all women.
- Improve access to quality primary and specialty care providers, including dental, for all children, particularly Children with Special Health Care Needs (CSHCN).
- Reduce adolescent birth rate.
- Increase breastfeeding rates among newborns.
- Promote healthy lifestyle practices among children and adolescents with emphasis on smoking prevention, adequate nutrition, regular physical activity, and oral health.
- Decrease intentional and unintentional injury death rates among children and adolescents.
- Reduce the prevalence of community, family, and domestic violence.
- Improve coordination and outreach with other health programs to facilitate delivery of health care services to CSHCN.
- Continue to expand the California Children's Services (CCS) statewide automated case management and data collection system, CMS Net, to improve tracking and monitoring services and outcomes for CSHCN.

The MCH Scope of Work (SOW), which is a part of the annual Allocation Funding Application (AFA), is developed based upon the four Title V MCH Goals, Fourteen Objectives for the current MCH Five-Year Plan (see above), and priorities.

The local jurisdiction's SOW consists of four required objectives. Objectives 1-3 define implementation activities, timelines, and methods of evaluating outcomes. They form the infrastructure of the local MCH program and are consistent for all 61 jurisdictions. Objective 4 is developed based on the individual needs of the jurisdiction as identified and discussed in the jurisdiction's five-year needs assessment.

- **Objective 1** details the responsibilities of the MCH Director to implement a local MCH program. Emphasis is on community collaboration, infrastructure development, and provision of family-centered, culturally competent services to improve health outcomes for the MCH population. The MCH Director is also responsible for the coordination and implementation of all the programs included in the MCH Allocation.
- **Objective 2** describes the patient/client education and community awareness and case finding activities to be undertaken by the MCH program. Patient/client education and community awareness activities must include targeted activities to low-income women and children to assist them in receiving early and continuous perinatal, infant, and pediatric preventive health care services.
- **Objective 3** describes the responsibilities of the Perinatal Services Coordinator (PSC). The PSC implements the Comprehensive Perinatal Services Program at the local level in addition to evaluating the perinatal care needs of the entire jurisdiction.
- **Objective 4** describes one or more locally defined priority issues. Every five years local agencies complete a Community Health Assessment. From this they developed a local Five-Year MCH Plan for their health jurisdiction consistent with the State Title V Plan. Objective 4 reflects the local health agency's priorities developed from its Community Health Assessment.

The purpose of the MCH allocation is to assist the jurisdiction provide leadership in planning, developing, and supporting comprehensive systems of preventive and primary care. This includes assessment of needs, coordination of effort at both state and local levels, planning to assure systems of care that achieve the health objectives set by the State and in conjunction with the national health objectives, and evaluation for identifying and incorporating best practices.

The format for the policies and procedures manual includes policies, requirements, and procedures for the following:

- 1.0 Local Activities**
- 2.0 Key Personnel**
- 3.0 Patient/Client Education and Community Awareness**

1.0 LOCAL ACTIVITIES

1.1 Policy: The State MCH Branch funds local health jurisdictions to carry out the core public health functions of assessment, policy development, assurance, and evaluation to improve the health of the MCH population through the AFA process.

1.2 Requirements:

1.2.1 Each jurisdiction receiving an allocation will address the selected goals and objectives contained in Scope of Work which was developed based on:

- MCH Policy and Procedures Manual
- Agency's Community Health Assessment and local MCH Plan
- Current Five-Year State MCH Application and Report

1.2.2 Based upon a local needs assessment, achieve selected objectives as negotiated with the program consultant and included in the SOW or as identified in the Five-Year Community Health Assessment.

1.2.3 Under the direction of the MCH Director, the jurisdiction will:

- Develop policies and standards and conduct activities that improve health outcomes for the MCH population.
- Develop agency and/or community infrastructures that provide family-centered, culturally competent services.
- Use core public health functions to assure that progress is made toward the selected 4 goals, 14 objectives, and 10 state MCH priorities.

1.2.4 Each jurisdiction must have an approved SOW that is consistent with the MCH Branch template (**Refer to Section MCH SOW**). Objectives 1 through 3 are standard for all jurisdictions. Objective four contains the activities specific to the jurisdiction as prioritized from their Five-year Community Health Assessment (refer to 1.2.6 below). The state MCH program consultant must approve the SOW and all changes.

1.2.5 Jurisdictions must continue to implement activities to address the objectives as identified in the SOW. They must define the implementation activities and/or interventions and define outcome measures that will be used to determine progress toward achieving improvements in these areas. Each implementation activity must have a method of

measuring or evaluating the outcome as it relates to meeting the objective. Local trends in MCH and the jurisdiction's progress in implementing their individualized plan should be a part of their Annual Report. Timelines must conform to the fiscal year for which the allocation applies. The timeframe for a particular objective or activity may be shorter than the fiscal year, but it cannot be longer than the fiscal year.

- 1.2.6** The five-year Community Health Assessment identifies the jurisdiction's priority(s). From the identified priorities, select one or more priorities for each fiscal year. Based on the selected priority(s) for objective four, specify one or more local implementation activities and appropriate evaluation processes or outcomes. All implementation activities must be appropriate, specific, and have a quantifiable or measurable effect within each fiscal year.

1.3 Procedures:

- 1.3.1** Unless specified otherwise, activities performed under this requirement shall be documented in writing as part of the Annual Report submitted to MCH (**Refer MCH Reports**).
- 1.3.2** Proposed changes to the SOW or the 5-Year Community Health Assessment must be submitted in writing and electronically with all corresponding documents to the MCH program consultant for review and approval within 30 days of the change. Please discuss proposed changes with the program consultant and contract manager if there are fiscal implications prior to submitting them for approval. The MCH Branch will respond in writing within 30 days after receiving all required documents and information.

2.0 PERSONNEL

- 2.1 Policy:** Each jurisdiction must have an MCH Director and a Perinatal Services Coordinator (PSC) that is approved by the State MCH. MCH Branch must approve all changes to the jurisdiction's MCH Director and PSC, including allocated time, duties, job specifications, and organization charts. Refer to the Federal Financial Participation Section of this manual.

2.2 MCH Director Requirements:

- 2.2.1** The MCH Director must be a qualified health professional, defined as:

- A physician who must be board-certified, or board-eligible, in specialties of OB/GYN, Pediatrics, Family Practice, or Preventive Medicine; or
- A non-physician who must be a certified public health nurse (PHN).

2.2.2 The MCH Director will dedicate a percentage of time to MCH activities that complies with the following MCH State Guidelines for the population.

MCH Director Chart
Health Jurisdiction Full-Time Equivalent

Total Population	FTE MCH Director
3.5 million	2.0 Physicians
750,001-3.5 million	1.0 Physician
200,001-750,000	1.0 Public Health Nurse
75,001-200,000	.75 Public Health Nurse
25,000-75,000	.50 Public Health Nurse
<25,000	.25 Public Health Nurse

2.2.3 All MCH Directors funded in whole or in part by the MCH Allocation Plan and Budget will be the lead for the local MCH program in the health jurisdiction.

2.2.4 The MCH Director, in collaboration with the local health officer, will have general responsibility and authority to plan, implement, evaluate, coordinate, and manage MCH services in the local health jurisdiction.

2.2.5 The MCH Director's role as the head of the local MCH program is to direct the local program to perform the core public health functions of assessment, policy development, assurance, evaluation, and the implementation of the approved SOW. The core functions are discussed below:

- **Assessment**
 - Participate in MCH Branch-sponsored training on data sources, data management, preparation of data for analysis, and the translation of data into information for program planning.
 - Monitor local health status indicators for pregnant women, infants, and children using standardized data techniques for the purpose of identifying at-risk populations, understanding the health needs in the community, and identifying barriers to the provision of health and human services for MCH populations.

- Identify health issues and interact with local health care providers and key informants to enhance programs and improve outcomes.
- **Policy Development**
 - Use information gathered during assessment to develop and implement local policies and programs to implement interventions.
 - Develop plans and direct resources consistent with program goals and objectives.
- **Assurance**
 - Facilitate access to care and appropriate use of services. This may include patient/client education and community awareness, referral, transportation, childcare, and translation services and care coordination.
 - Must have a toll free or "no cost to the calling party" telephone system which provides a current list of available culturally and linguistically appropriate information and referral to community health and human resources and the general public regarding access to prenatal care. The telephone number must be disseminated widely throughout the health jurisdiction by means of pamphlets, publications and media publicity. At a minimum, the toll free line must be operational during normal business hours and must be linguistically appropriate. Personnel staffing the toll-free line should have cultural sensitivity training. After-hours messages must be answered by the end of the following business day.
 - Coordinate all MCH patient/client education and community awareness services from various programs to prevent duplication of service and for optimal use of resources.
 - Participate in quality assurance activities in order to improve community health indicators for women, children, and families.
 - Attend Maternal Child and Adolescent Health Action meetings and other required trainings.

- **Evaluation**

- Based on activities of assessment, policy development, and assurance, evaluate program and modify program to ensure best practices.
- Include in selected local priority activities methods of measuring outcomes and evaluating progress toward achieving both state and local MCH objectives. This evaluation is included in the semi-annual and annual reports to the state MCH Branch.

2.3 Perinatal Services Coordinator (PSC) Requirements:

- 2.3.1 Based upon the local birth rate, each health jurisdiction must have a PSC that meets the time and professional requirements identified in the table below. When determining the appropriate FTE for a jurisdiction, consider the number of Medi-Cal births and obstetric providers, and geographic issues.

PSC Chart
Health Jurisdiction Full-Time Equivalent*

Total Number of Births	FTE PSC
100,000	2.0 SPMP
20,001-100,000	1.0 SPMP
5,001-20,000	.75 SPMP
1,000-5,000	.50 SPMP
<1,000	.25 SPMP

- 2.3.2 Process applications for those eligible providers desiring to become approved CPSP providers.
- 2.3.3 Provide consultation and technical assistance to prenatal care providers including FQHC/95-210 clinics and managed care plan contractors, in the implementation of Title 22, CCR Sections 51170 et seq. relating to comprehensive perinatal services.
- 2.3.4 Assist providers to deliver CPSP services in accordance with Title 22 California Code of Regulations.
- 2.3.5 New PSC must attend a new coordinator orientation.

2.3.6 Attend state-sponsored PSC meetings and other required trainings and related activities, such as task force committee for coordination and operation of this program.

2.3.7 Must participate in the functions of assessment, policy development, assurance, and evaluation as discussed below and assist in the implementation of the local CPSP:

- **Assessment**

- Monitor trends in access and quality of prenatal care, including the adequacy of the obstetrical provider network and its ability to meet the needs of the target population; and
- Identify areas that have disproportionately high need in relation to access to care and other barriers to the delivery of appropriate and timely prenatal care, e.g., substance abuse, ethnic/cultural groups.

- **Policy Development**

- Use information gathered during assessment to develop and implement local policies and programs to implement interventions.
- Participate in local planning to address unmet needs to provide access to first trimester care for all pregnant women.

- **Assurance**

- Undertake quality assurance activities, as appropriate, with CPSP providers and managed care plans and participate in regional and statewide CPSP advisory committees/workgroups.
- Address issues related to access and quality of perinatal care.
- Assure the availability of comprehensive perinatal services to all Medi-Cal-eligible women in both fee-for-service and capitated health care systems.
- Facilitate meeting the needs of providers and managed care plans for updated materials, resources, and information on CPSP and the needs of the target population.

- Work with the perinatal community, including providers, managed care plans, and other health and human service providers to reduce barriers to care, avoid duplication of services, and improve communication.
- Inform the perinatal community, including providers, managed care plans, and other health and human service providers about local status and trends of perinatal outcomes and their relationship to the MCH yearly plan.
- Educate the provider community, including providers, managed care plans, and other health and human service providers about CPSP, the needs of the target populations and sub-populations, such as the homeless, substance using, and migrant workers, etc.
- Collaborate with providers and other third-party payers to extend comprehensive perinatal care to all pregnant women at or below 200 percent of poverty.
- Conduct provider education and continuous quality improvement programs that will reduce perinatal mortality and morbidity.
- Promote, develop, and coordinate professional and community resources that will serve the multidisciplinary needs of the pregnant woman and her family.
- **Evaluation**
 - Based on activities of assessment, policy development, and assurance evaluate program and modify program to ensure best practices.
 - Incorporate assessment findings and activities to improve services (if indicated) in the jurisdiction's Community Profile and Local MCH Plan.

2.4 Procedures for Key Personnel:

- 2.4.1** Maintain documentation of activities on file (Refer to Audit Section of this manual).

- 2.4.2 **Annual Reports**--Summarize activities and describe outcomes/impact in the Annual Reports in accordance with current fiscal year Policies and Procedures.
- 2.4.3 **Key Personnel**--Notify MCH Branch Chief in writing of resignation of key personnel within seven days of resignation notice.
- 2.4.4 **Selection of Candidate**--Send a letter to MCH Branch Chief notifying them of the candidate selected within seven days of selection of the candidate. This letter will include qualifications of selected candidate, their license(s) number, and effective start date. MCH will respond within seven days as to approval of candidate. If the candidate does not meet requirements, the agency may request a waiver to the requirement. MCH Branch will consider a waiver to key staff policy if an agency is unable to provide the full-time equivalent for either the MCH Director or PSC at the time allocations detailed in the requirement charts. A Key staff waiver is for a specific person and remains in place only as long as that person occupies the position for which the waiver is approved. If the person who was issued a waiver changes positions or leaves employment with the agency, the waiver is void. MCH will not reimburse an agency for MCH Directors and PSC who do not meet the minimum educational and time commitment requirements, unless a waiver is on file in the MCH Branch.
- 2.4.5 **Revised Duty Statements**--Submit revised duty statements, job specifications, organizational charts, Medi-Cal justification, and annual budget if the proposed change involves a change in the allocated time (full-time equivalent) or involves new or changed duties.
- 2.4.6 **Key Staff Waiver**--Submit to MCH Branch a written request for a key staff waiver that outlines the circumstances for the waiver and the qualifications of the person or persons who will be filling the position. MCH will respond within seven days of receiving the request. Submit a copy of the approved key staff waiver with the Annual Report along with an explanation for continuing the waiver with other documents for the Allocation Funding Application (AFA) negotiations.

2.5 Duty Statements Requirements:

2.5.1 As a part of the AFA, current duty statements for personnel identified on the budget shall be used as supporting documentation for the percent of time assigned to MCH program activities and level of Federal Financial Participation (FFP) match. Duty statements must:

- Accurately reflect the MCH activities.
- Contain only those duties performed for the MCH program, or specific program duties.

Refer to MCH Forms/Exhibits Duty Statement Template

2.5.2 Duty statements must provide sufficient information, i.e., targeted populations, targeted geographic areas, specific practice settings or specific functions, to justify the matching level of Medi-Cal administrative claiming (FFP) that is requested. Duty statements need not include the percents of time for Medi-Cal administrative claiming (FFP) that is requested on the Budget.

2.5.3 The description of duties contained in the Duty Statement will be consistent with:

- The Position Title on the Personnel Detail Sheet of the Budget
- The level of Medi-Cal administrative claiming (FFP) requested on the Budget
- The Budget Justification.

2.5.4 Duty Statements for Skilled Professional Medical Personnel (SPMP) will note 'SPMP' at the top of the Duty Statement or along with the position title.

2.5.5 Agency job specifications must signify they require SPMP, if enhanced funding match is claimed.

2.5.6 All personnel funded through the local MCH Budget need duty statements, which describe those activities funded through the MCH Allocation or directly related to the MCH program. The titles should match those on the organizational chart, budget, and budget justification.

2.6 Procedures:

- 2.6.1 Maintain on file a copy of the county's duty statements and job specifications for SPMP positions and all duty statements. This must be available to the MCH Branch upon request.

2.7 Organizational Charts Requirements:

- 2.7.1 Each agency must have an organization chart for all MCH programs and any special programs they have which:
- Identifies the MCH program and its relation to other public services for women and children;
 - Illustrates the relationship of MCH personnel and programs to the MCH Director, the local health officer, and overall agency; and
 - Identifies all staff positions funded through MCH funds or involved in MCH activities. Staff positions should match the duty statement titles. The budget line number, and initials of the staff member should be listed on the organizational chart for ease of identification with the positions in the budget and budget justification.

2.8 Procedure for Organizational Chart:

- 2.8.1 The local organizational charts are submitted to MCH as a part of the AFA, along with the current duty statements for Personnel identified on the budget and shall be used as supporting documentation for the percent of time assigned to local MCH program activities and the level of FFP match.

2.9 Training and Meeting Requirements:

- 2.9.1 Adequate funding for training and meeting expenses, including travel, must be built into the annual budget.

2.10 Procedures for Training and Meeting Requirements:

- 2.10.1 Include as a line item in the budget adequate funding for training and meeting expenses.

3.0 PATIENT/CLIENT EDUCATION AND COMMUNITY AWARENESS

- 3.1 Policy:** All MCH local jurisdictions must have Patient/Client Education and Community Awareness Activities.

3.2 Patient/Client Education and Community Awareness Requirements:

- 3.2.1 Under the direction of the MCH Director, the agency must provide a coordinated local effort for patient/client education and community awareness and case finding activities for low-income, high-risk women of childbearing age, pregnant women, and children.
- 3.2.2 The agency is responsible for a variety of patient/client education and community awareness activities that recognizes the diversity of effective approaches needed to serve California's heterogeneous population. These activities should include promoting other local programs to increase access to perinatal care and preventive health care services for children, such as Access for Infants and Mothers (AIM), the Healthy Families program for children, and integrated activities within the MCH Scope of Work, such as Prenatal Care Guidance.
- 3.2.3 The agency must track client referrals to obtain unduplicated counts of those receiving patient/client education and community awareness services and summarize the results in the Annual Report.
- 3.2.4 Each health jurisdiction must provide coordinated patient/client education and community awareness activities to:
 - Inform low-income pregnant women and women of childbearing age, other target groups, and the agencies that provide services to them of:
 - The need for early and continuing prenatal care.
 - The availability and sources of prenatal care.
 - The Medi-Cal application process.
 - Follow high-risk targeted Medi-Cal-eligible women to assist them in continuing prenatal care and to assist them in obtaining other needed services.
 - Assist families with infants and children who are eligible to obtain state-funded health coverage through Medi-Cal, AIM, Healthy Families and Child Health and Disability Program (CHDP) so they can access appropriate medical

care and meet the recommended preventive health visits for their child.

3.2.5 Patient/client education and community awareness, case finding, and care coordination activities shall be targeted to high-risk populations as identified in the jurisdiction's Five-Year MCH Plan. Priority is given to the following populations:

- Low-income pregnant women.
- Women, children, and adolescents who are not linked to a source of care.
- Women of childbearing age who are at risk for adverse perinatal outcomes, including but not limited to, tobacco exposure and substance use.

3.2.6 The agency will promote community-wide collaboration in the development and implementation of patient/client education and community awareness programs, as well as work to assure that services are provided in a culturally sensitive manner and avoid duplication of services.

3.2.7 The agency must develop protocols and evaluation methods to measure the success of activities as they relate to the local MCH Plan and the Scope of Work.

3.2.8 The agency must keep a log of incoming calls and referrals to assist in evaluating utilization. This information is reportable in the MCH Annual Report. Please refer to the Progress Report Requirements, Toll-Free Telephone Report (Form 6) in the Report Section, for necessary revised reporting requirements for the Annual Report.

3.3 Procedures:

3.3.1 Maintain documentation of activities on file (Refer to Audit Section of this manual).

3.3.2 Summarize activities and describe measures of success and outcomes/impact in the Annual Reports in accordance with current fiscal year Policies and Procedures.